MISSISSIPPI STATE DEPARTMENT OF HEALTH
PILOT FREESTANDING EMERGENCY DEPARTMENT (PFED)
APPLICATION PROCEDURES

Introduction

The Mississippi State Department of Health is seeking proposals for a Pilot Freestanding Emergency Department (PFED). The PFED would be designed to decrease the wait and length of stay times for patients with critical conditions that require inpatient treatment and decrease ambulance diversion as non-emergency patients move to the FED and open the flow of true emergencies to hospitals. This pilot represents an effort to provide the essential service of Emergency Medicine to Mississippians in the challenging time of 5% decreases in emergency departments nationwide; while emergency department visits have increased by 32%. The target patient population for this pilot is 6,000 patient visits per year. The PFED shall be solely a provider-based unit of a licensed Mississippi acute care hospital and comply with all applicable Medicare provider-based regulations. Therefore, only Mississippi licensed hospitals may submit a proposal.

Application Process

Interested applicants must submit Notice of Intent (NOI) by March 1, 2014. Proposals and applications must be received by the Department no later than April 1, 2014. Submit the original and five (5) copies of the proposal to:

Don Eicher, Director
Office of Health Policy and Planning
Mississippi State Department of Health
P. O. Box 1700
Jackson, MS 39215-1700

The minimum fee for processing PFED applications shall not be less than $1,250.

Should the applicant propose any services or expenditure that cross the Certificate of Need (CON) thresholds, the usual CON fees shall apply (The fee for processing CON applications is .005 times the capital expenditure stated in the application plus .0025 times the capital expenditure stated in the application (minimum $1,250 and the maximum is $75,000).

Fee payment shall accompany the PFED application and is payable to the Mississippi State Department of Health by check, draft, or money order. The assessed fee, once paid, shall be non-refundable.

No application shall be deemed complete for the purpose of review until the required fee is received by the Department.

Complete applications will be entered into the 90-day review period beginning May 1, 2014 and ending July 30, 2014. Guidelines contained in the CON Review Manual, 2011 Revision, regarding Certificate of Need Application Procedures shall be followed.

MSDH USE ONLY
CON Review #:_____
Date NOI Received:_____
Fee: $_____ Rec'd: Y N

MISSISSIPPI STATE DEPARTMENT OF HEALTH
CERTIFICATION

APPLICANT: _____

TITLE OF PROPOSED PROJECT**:** **Pilot Freestanding Emergency Department**

TOTAL CAPITAL EXPENDITURE: _____

I (we) swear or affirm on behalf of _____ , after diligent research, inquiry and study, that the information and material contained in the attached application for a Pilot Freestanding Emergency Department (FED) is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health will rely on this information and material in making its decision as to the issuance of a Certificate of Need, and if it finds that the application contains distorted facts or misrepresentation or does not reveal truth or accuracy, the Department may refrain from further review of the application and consider it rejected. It is further understood that if a Certificate of Need is issued based upon evidence contained in this application, such Certificate may be revoked, canceled or rescinded if the Department of Health determines its findings were based on evidence, not true, factual, accurate, and correct.

I (we) have read the guidelines contained in the Minimum Standards of Operation for Mississippi Hospitals pertaining to FEDs and hereby certify that the FED will meet all rules, regulations, and guidelines contained therein. Furthermore, I (we) will furnish to the Department of Health all data required by the Department in a timeframe specified by the Department.

_____ _____
Type or Print Name Signature

_____ _____
Title Facility (if different than above)

STATE OF _____

COUNTY OF _____

Sworn to and subscribed before me, this the _____ day of _____20___

_____
Notary Public

_____
My Commission Expires

MISSISSIPPI STATE DEPARTMENT OF HEALTH
APPLICATION FOR A PILOT FREESTANDING
EMERGENCY DEPARTMENT (PFED)

LOCATION OF PROPOSED PROJECT:	
Capital Expenditure:	**$**

I. APPLICANT/FACILITY INFORMATION

APPLICANT					
Applicant Legal Name:					
d/b/a (if applicable):					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			
Parent Organization (if applicable):					
E-mail Address:		Fax:			
PRIMARY CONTACT PERSON					
Name:		Title or Position:			
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			
E-mail Address:					
LEGAL COUNSEL/CONSULTANT (if applicable)					
Name:		( ) Attorney	( ) Consultant		
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			
E-mail Address:					

1. If the name of the existing or proposed facility is different than the Applicant's legal name provide the facility information.

FACILITY					
Facility Name:					
Facility Address:					
City:		State:		Zip Code:	
County:		Phone:			

2. Will the existing or proposed facility be operating by a different Management Entity other than the Applicant? If yes, provide the following information and submit any existing or proposed management agreements.

MANAGEMENT / OPERATING ENTITY					
Organization Name:					
Address:					
City:		**State:**		**Zip Code:**	
Telephone:		**Fax:**			

3. Select the type of ownership of present or proposed facility.

TAX EXEMPT	☐ Not-for-Profit Corporation		
	☐ Public (Hospital or Government)		
TAX PAYING	☐ General Partnership	☐ Business Corporation	☐ Sole Proprietor
	☐ Limited Liability Partnership or Limited Partnership	☐ Limited Liability Company	
State of Incorporation / Organization:			

4. Please provide documentation of the organizational and legal structure as indicated in the table below.

ORGANIZATIONAL STRUCTURE	
Not-for-Profit Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Public	▪ All Governing Authority Approvals for this Project
Sole Proprietor	▪ County Business Authorization Documents, if available
General Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Partnership Agreement
Limited Liability Partnership or Limited Partnership	▪ Name, Partnership Interest, and Percentage Ownership of Each Partner ▪ Letter of Good Standing from Secretary of State
Business Corporation	▪ Name of Each Officer and Director ▪ Letter of Good Standing from Secretary of State
Limited Liability Company	▪ Name of Each Member and Managing Member, Officers, and/or Directors ▪ Letter of Good Standing from Secretary of State

II. PROJECT DESCRIPTION

1. Describe in detail ALL of the characteristics of the proposed project.

2. Provide the anticipated date for obligation of capital expenditure (_____) and the anticipated date the project will be complete (_____). No project will be deemed complete without this information.

3. Provide evidence that the Division of Licensure and Certification has approved the site of construction or new service. No project will be approved unless the site has been approved. (If site approval is not necessary, provide statement from the Division of Licensure and Certification stating that site approval is not necessary for this project.).

4. **List equipment costing in excess of $150,000 and attach copies of any equipment leases or rental agreements, if applicable.**

5. If the proposed project involves New Construction and/or Renovation:

a. Describe the new construction and/or renovation (including but not limited to site work, grounds work, drainage, parking, fencing, mechanical and electrical systems). Also state square footage requirements and identify current and/or proposed use of all space.

b. Enclose plot plan of site. If proposed project includes construction, modernization, or alteration of the physical plant, enclose schematic drawings (8½" x 11" format).

c. Provide documentation that the applicant will or has complied with state and local building codes, zoning ordinances, and/or appropriate regulatory authority.

d. Affirm that applicant will comply with all applicable State statutes and regulations for the protection of the environment, including: 1) approved water supplies; 2) sewage and water disposal; 3) hazardous waste disposal; 4) water pollution control; 5) air pollution control; and 6) radiation control.

e. If the project involves the renovation of an existing facility and the facility has licensure code or accreditation standard deficiencies, enclose a copy of the most recent report or survey from the licensing authority or accreditation program citing deficiencies.

III. CERTIFICATE OF NEED CRITERIA AND STANDARDS

A. *MINIMUM STANDARDS OF OPERATION*

1. **The applicant shall affirm that the PFED shall be a solely provider-based unit of a licensed Mississippi acute care hospital and comply with all applicable Medicare provider-based regulations.**

2. **Affirm that the PFED shall comply with all regulations that apply to clinical services and staffing for emergency departments, as set forth in the MSDH Minimum Standards of Operation for Mississippi Hospitals and is located within 35 miles of the licensed hospital with which it is affiliated, and at least 10 miles away from any other licensed hospital.**

3. **Affirm that the PFED will provide data to the appropriate Trauma Region and the department's Trauma Registry through the hospital's participation in the Mississippi Trauma Care System (MTS).**

4. **Affirm that the PFED will contain at a minimum the equipment listed in Rule 41.83.5 through 41-83-10 of the Minimum Standards of Operation of Mississippi Hospitals.**

5. Affirm that the required classes of drugs and agents stated in Rule 41.83.11 will be available. The medical director of the PFED, representatives of the medical staff, and the director of the pharmacy shall develop a formulary of specific agents for use in the PFED.

6. Certify that the following services will be available 24 hours a day for emergency patients: (The specific services available and the timeliness of availability of these services for emergency patients in PFED should be determined by the medical director of the PFED in collaboration with the directors of the diagnostics services and other appropriate individuals.

- **A. Standard radiologic studies of bony and soft-tissue structures including, but not limited to: cross-table lateral views of spine with full series to follow: Portable chest radiographs for acutely ill patients and for verification of placement of endotracheal tube, central line, or chest tube; Soft-tissue views of the neck; Soft-tissue views of subcutaneous tissues to rule out the presence of foreign body; Standard chest radiographs, abdominal series, etc.**
- **B. Pulmonary services: Arterial blood gas determination; peak flow determination; Pulse oximetry**
- **C. Fetal monitoring (nonstress test)/uterine monitoring**
- **D. Cardiovascular services: Doppler studies; 12-Lead ECGs and rhythm strips;**
- **E. Emergency ultrasound services for the diagnosis of obstetric/gynecologic, cardiac and hemodynamic problems and other urgent conditions.**

7. Certify that the following services shall be available on an urgent basis, provided by staff in the Affiliated Hospital or by staff to be called in to respond within a reasonable period of time: Nuclear medicine, Radiographic, and vascular/flow studies including impedance plethysmography.

8. Document that the medical director of the PFED and the director of laboratory services have developed guidelines for availability and timeliness of services for the PFED to include, but not limited to the following: Blood bank, Chemistry, Hematology, Microbiology, and other screenings.

9. Certify your understanding and compliance with the following policy regarding Transfer of Unstable Patients from PFED to Acute Care Hospital:

Once the patient is determined to require a higher level of care than can be provided at the PFED, Physician shall immediately contact the designated EMS for transport. If the EMS is based on site, the

transport team will be notified immediately. The Physician will stabilize the emergency medical condition and determine the transfer destination based on the specialized capabilities of facilities that are offered at local hospitals. If the destination hospital is the affiliated PFED facility all procedures and protocols for acutely ill patients will be implemented before departure from the PFED. Such conditions would include, but not limited to, STEMI, acute ischemic stroke and Cardiac Arrests. All electronic medical records and any diagnostic test results will be transported with the patient to the receiving facility. Goal transport time should be <30 minutes. Should a patient meeting trauma system activation requirements arrive at the PFED the PFED will transfer the patient in accordance with the state Trauma Plan.

10. Certify that the applicant will provide all information requested by the Department within a timeframe to be specified by the Department.

B. *CERTIFICATE OF NEED (CON) MANUAL*

Criterion 1 – State Health Plan: All projects will be reviewed for consistency with the State Health Plan in effect at the time of submission.

Criterion 3 - Availability of Alternatives: Identify alternative approaches to the project which were considered.

a. Demonstrate in specific terms how the FED most effectively benefits the health care system.

b. If an effective and less costly alternative for the proposed project is currently available in the area, demonstrate:

i. Why the proposed project is a more efficient solution to the identified need.

c. Explain the relevancy of the proposed project in relation to changing trends in service delivery and community health care needs of the foreseeable future.

Criterion 4 - Economic Viability:

a. Discuss both the proposed charges for the service and the profitability of the proposed service compared to other similar services in the service area or state. Document how the proposed charges were calculated.

b. Discuss whether projected levels of utilization are reasonably consistent with those experienced by similar facilities in other states and whether the projected utilization level is consistent with the need level of the service area.

c. **Describe how the applicant will cover expenses incurred by the proposed project in the event that the project fails to meet projected revenues.**

d. **Discuss the impact of the proposed project on the cost of health care. This discussion should include the proposed project's impact on gross revenues and expenses per patient day or per procedure as well as the impact on Medicaid, if applicable.**

Criterion 5 - Need for the Project:

a. **Discuss the need that the population served or to be served has for the services proposed to be offered and the extent to which all residents of the area - in particular low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly - are likely to have access to those services.**

b. **Discuss the probable effect of the proposed facility or service on existing facilities providing similar services to those proposed. When the service area of the proposed facility or service overlaps the service area of an existing facility or service, then the effect on the existing facility or service may be considered. The applicant or interested party must clearly present the methodologies and assumptions upon which any proposed project's impact on utilization in affected facilities or services is calculated. Also, discuss the appropriate and efficient use of existing facilities/services.**

c. **Document the community reaction to the facility. Submit letters of comment from: 1) physicians; 2) health care facilities; 3) consumers and; 4) health related community agencies in your health planning area. Also include letters of comment from city, county, or area government officials, if applicable.**

Criterion 6 - Access to the Facility or Service:

a. **Discuss the extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved and the extent to which medically underserved populations are expected to use the proposed services if approved.**

1. **Do all residents of the health planning service area, hospital service area or patient service area, including Medicaid recipients, charity/medically indigent patients, racial and ethnic minorities, women, handicapped persons and the elderly have access to the services of the existing facility?**

☐ Yes ☐ No ☐ Not Applicable

2. **Will these residents have access to the proposed services and/or facility as described in this application?**

   ☐ Yes ☐ No

<u>Criterion 7 - Information Requirement:</u> Affirm that you will record and maintain, at a minimum, the following information regarding charity care, care to the medically indigent, and Medicaid populations and make it available to the Department within 15 business days of request:

- **Utilization data, e.g. number of indigent, Medicaid, and charity admissions, and patient days of care;**
- **Age, race, sex, zip code, and county of origin of patient;**
- **Cost/charges per patient day and/or cost/charges per procedure, if applicable; and**
- **Any other data pertaining directly or indirectly to the utilization of services by medically indigent, Medicaid, or charity patients which may be requested; i.e. discharge diagnosis, service provided, etc.**

<u>Criterion 8 - Relationship to Existing Health Care System:</u>

a. **Identify any existing, comparable services within your service area and describe any significant differences in population served or service delivery. If there are no existing, comparable services in the area, describe how the target population currently accesses the proposed service(s).**

b. **State how the proposed project will affect existing health services available in the region or statewide, if applicable. Describe how each proposed new or expanded service will:**

   i. **Complement existing services.**

   ii. **Provide an alternative or unique service.**

   iii. **Provide a service for a specific target population.**

   iv. **Provide services for which there is an unmet need.**

c. **Describe any adverse impact to the existing health care system that may result from failure to implement the proposed project.**

<u>Criterion 9 - Availability of Resources:</u>

a. **Document the availability of staff and resources necessary to evaluate all individuals presenting to the emergency department, to include, but not limited to the following:**

1. **Experienced board certified or board qualified physicians, nursing and ancillary personnel (available 24 hours a day)**
2. **Ability to provide or arrange treatment and transport to attempt to stabilize emergency patients who are found to have an emergency condition.**
3. **Ability to provide treatment for individuals whose health needs are not of an emergent nature, but for whom the PFED may be the only accessible or timely entry point into the broader health care system.**

b. List applicant's policies and plans to provide effective administration, staffing, facility design, equipment, medication and ancillary services.

Criterion 13 - If the applicant proposes to provide service(s) to individuals not residing in the service area, document any special needs or circumstances that should be considered.

Criterion 15 - Competing Applications: (Should competing applications be received, the Department may contact the applicant for any additional required information).

Criterion 16 - Quality of Care:

a. Describe how the applicant has demonstrated past quality of care.

b. Describe how the proposed project will improve the quality of care being delivered to the target population.

c. List any accreditation and/or certifications held.

IV. FINANCIAL FEASIBILITY:

CON Application Financial Analysis (Excel spreadsheet) consists of seven (7) tables that must be completed and submitted along with application.

Copies of financial statements are required with each application. Please provide audited financial statements when possible. Audited financial statements to be submitted must include, at a minimum, balance sheet, operating statement, and cash flow statement. Be sure financial information for the last three years is included.

Submit a Depreciation Schedule.